LETTERS TO THE EDITOR

SIR:

I was interested to read in the September issue of the Canadian Anaesthetists' Society Journal the letter by Dr. David A. E. Shephard, urging the Canadian Anaesthetists' Society to consider the "Development of a universal and uniform technique for the collection of data."

I would point out that in the Province of Alberta there is a committee set up by the Alberta Medical Association, consisting of two anaesthetists, a surgeon, and a pathologist, whose function it is to review all charts of patients who have died within three days of surgery and/or anaesthesia.

This work is invaluable in a local sense in that it has formed the basis for a Refresher Course in Anaesthesia for General Practitioners, and occasional letters can be written where errors of technique are discovered. It is not, however, of much value from a straight statistical point of view, as too much of the work is not assessable in a very accurate manner.

To rectify this, one would need to have not only standardized anaesthetic cards, but a standardized method of filling them out, which I imagine would be impractical, human nature being what it is. I would strongly urge that each province use its own committee in a close liaison with its further educational training programme, where it could serve a very real function. Anything more than this would entail an enormous amount of work with little useful reward.

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SIR:

In discussing the analysis of deaths associated with anaesthesia¹ Dr. Shephard² has made a plea for the development of a standardized form of record. His suggestion deserves the most serious thought, and even some amplification.

The full understanding of a death which occurs during or after an anaesthetic often depends not only on the accurate recording of the progress of anaesthesia but upon a comprehensive knowledge of the preoperative history and condition of the patient, and sometimes also of postoperative events. It is thus properly regarded as an exercise not so much in record keeping as in record linkage.

The problem of linkage is inherent in anaesthetic records: as usually conceived they are a mixture of two things, a short-term record of present events, relating to the anaesthetic, and a précis of past and future information, relating to the preoperative and postoperative periods. The mixture is never a good one and in

some cases the complexity of the past or the future, as for instance when an ill patient spends some days in an intensive care unit, makes it impossible to achieve a proper proportion. I have collected and examined anaesthetic record cards from many countries. None is satisfactory. The simplest are worthless; the most comprehensive include so much information that they are, in effect, a reduplication of the entire surgical in-patient record; between the extremes are those which most of us, with a great sense of hopelessness, complete and consign forever to the vaults of the hospital.

What is needed is a series of records: a preoperative record, an anaesthetic record, an operation record, a recovery room record, and so on. No information should go unrecorded and none should be recorded more than once. All records should be retrievable and it should be possible to link all records relating to a single patient. By extension, the records from other hospitals should also be retrievable and linkable so that the patient's previous experiences, those of his relatives, and those of similar patients can be studied. Finally, the relevant records of visits to the general practitioner, of immunization, of mass radiography, of birth, marriage, and death should, if needed, be available to complete the picture.

This concept of medical record linkage is not new.³ It is not impracticable.⁴ Canada has a better basis on which to build than any other nation in the world; Newcombe⁵ in his work in British Columbia has already demonstrated the value of the record linkage possibilities which are currently available in his studies of population genetics.

We are at present making plans, with the Department of Computing Science of the University of Manitoba, for the automation of many activities in a new hospital to be built in Winnipeg. It is our intention to use the anaesthetic record as a starting point for the storage and retrieval of in-patient data. From this we propose to build backwards and forwards in time to embrace pre- and postoperative records. It will then be for us, as anaesthetists, to decide what type of abstract of preoperative information we wish the computer to conjure up for us when the patient arrives in the theatre and what postoperative information we think it necessary to elicit in the wards for our subsequent researches. My personal hope is that this will lay the foundation for a wider record linkage scheme.

There is an opportunity here to make an important contribution to our own specialty and to the recording of medical data in general. I do not know whether the Canadian Anaesthetists' Society is disposed to listen to Dr. Shephard, but if funds are available I can think of few better ways of using them.

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REFERENCES

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2. SHEPHARD, D. A. E. *Canad. Anaesth. Soc. J.* 14: 486 (1967).
3. DUNN, H. L. *Am. J. Pub. Health.* 36: 1412 (1946).
4. ACHESON, E. D. *Medical Record Linkage*. London: Oxford University Press (1967).
5. NEWCOMBE, H. B. *Canad. J. Genet. & Cytol.* 1: 13 (1959).

SIR:

My attention has recently been called to an article in your issue of September 1967 in which, under the title *An Anaesthetist's Valediction*, one H. Griffith misrepresents himself. We are asked to accept that the author of this autobiographical ramble is just an ordinary Joe who backed into his contributions to the field of anaesthesia by luck or by knowing the right people. I must protest this imposture of the self-confessed little homeopathic Montrealer because I know better. This man has contributed more during his lifetime to the advancement of anaesthesia (anaesthesiology?) than any other of our contemporaries.

I saw him while masquerading in the Second German War in the uniform of a Wing Commander, R.C.A.F. His expeditions at the taxpayers' expense were missionary visitations and his zeal was applied to Navy, Army, or civilian colleagues without discrimination.

He has cleverly concealed his involvement with the Department of National Revenue in a celebrated tax case while promoting Canada's participation in an organization of the anaesthetists of the world. As I recall it, he did not win this one but his experience has led to conditions which are much more favourable to Canadian doctors at international congresses than they were previously.

Really, sir, I must protest this effort at self-deprecation and ask you to permit me to expose the author as one of the leaders of our profession.

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